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ABSTRACT

This document contains a suicide management plan developed specifically for colleges. The suicide management plan described includes pre-planning, immediate response to the event, press releases, college staff jobs, college responses (such as memorials or scholarships), interaction with the family, and staff counseling. The plan is presented as a form, with spaces for the institution to record its particular responses. Also included is the Violence Epidemiology Branch Press Book describing the branch and its activities. It notes that the purpose of this group is to reduce the incidence of violence-related morbidity and mortality in the United States. Contained in the Press Book are statistics on homicide and suicide as well as bibliographies and resource lists for materials on interpersonal violence and suicide. A bibliography on teen suicide from the American Association for Counseling and Development is also included. (ABL)

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SUICIDE MANAGEMENT PLAN - POST SUICIDE RESPONSE

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The epidemic proportions of suicide today necessitate preparedness. Because of the possible clustering and suggestibility of a self-inflicted fatality, a well-planned and thoughtful response may be crucial toward abating more trauma. The enclosed plan is not intended to be exclusive and thoroughly specific, but rather a roadmap to suggest concerns which require pre-thought decisions and carefully constructed responses for various settings.

Also enclosed is a bibliography constructed by the Atlanta Center for Disease Control regarding Suicide.

It is intended that this work will help you deal appropriately with what we all hope to avoid: mismanagement of a tragic event which precipates further tragedy.

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SUICIDE MANAGEMENT PLAN - POST SUICIDE RESPONSE

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1. Homework: Contact local T.V., Radio, Newspapers, and Student Newspapers to discuss policies in dealing with suicides. Discuss responsibility and ethics for contagion and clustering.

   Contact Persons: _____

   _____

   _____

   Preplan for coordination of communication from first alert services, i.e. Campus Safety officials and switchboard personnel -- know who is to be covered and in what order (plan for unavailability) and what is to be communicated. Plan limits of communication. (Who needs to know?)

   _____

   _____

   _____

THE EVENT

2. Determine immediacy of emergency . . . call emergency services. (Police--Fire--Ambulance) 911 or appropriate numbers. Control flow of information.

   _____

   _____

   _____

3. Secure the immediate and secondary areas -- staff should limit all access or egress.

4. Staff should direct students to remain in their rooms should police or officials wish to question.

   . . . to prevent tampering
   . . . to prevent being in the way
   . . . to prevent crown hysteria
   . . . to limit flow of information
   . . . to prohibit curiosity with lasting negative consequences

5. Designated official should contact counseling staff, medical staff and religious staff to come on site to deal with hysteria and shock.

Counseling Staff	Medical Staff	Religious Staff
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

6. Designated official should contact University officials -- who? President? Deans? Attorney?

President	Deans	Others
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Be prepared to wait for appropriate public investigators and rising hysteria.

Names of Emergency and Investigative Personnel	Phone Numbers
_____	_____
_____	_____
_____	_____

8. After authorities allow, contact parents or appropriate legal representatives. Caution: it may not be appropriate to call the family directly. Call twice, leave name and number of contact person. First call may inform, but family will have many questions after initial shock. It is advisable to contact pastor, priest or rabbi or other

9. Prepare statement for press and determine appropriate official to appear. Parents may not want name released. Press will do what they will,

Person to Release Statements

_____

_____

10. Make sure no other student has the same name as the deceased.

11. PLAN FOR HYSTERIA AS THE NEWS SPREADS.
Local and Specific Concerns: Shock, Heart Patients. Students - Staff? Do you know who may react adversely?

Persons of Concern: _____

_____

_____

12. Have procedures outlines for residence staff -- (who are the potential suicide risks.) Assist Resident Staff in being knowledgeable as to what is expected. Have "dry run" with counseling and medical team to prepare.

Our Plan: _____

_____

_____

_____

13. Outline established for support staff, i.e.,

-- counseling staff check files for potential suicidal risks. Specific tasks: _____

_____

_____

-- medical staff prepare to admit or sedate. Specific tasks:

_____

_____

_____

-- religious staff prepare to serve. Specific tasks: _____

_____

_____

_____

-- faculty prepared to assist or recognize implications. Specific plans: _____

_____

_____

-- possible emergency housing plans if area must be made secure. Contingency plan: _____

_____

_____

14. Open an auditorium or chapel to make formal statement, to control emotions, give direction and begin closure as well as assistance to those in need. Offer resources to those who may need them. Provide structure (closure plan) what's next? Specific area and possible. Plan:

_____

_____

15. Next day, informal regroup . . . provide more assistance, notify mail office to attend to mail and all mailing lists, allow for venting for those who need it, give permission for individual means of handling grief. Explain the grief process. (What to expect corporately, individually.) Specific location and who is responsible:

_____

_____

16. Clean and vacate the room of suicide as soon as authorities will allow . . . be assertive to do it immediately. (Clean room of all furniture and leave unlocked and open.) Emergency maintenance personnel procedures:

_____

_____

17. Plan for and provide additional support for your Residence Staff. Most of them are not trained for continuing intensity. What will you do to equip your staff? _____

_____

_____

18. Stress small special group support if necessary. Who will plan and direct your special group to (regroup)? _____

_____

_____

19. Plan memorial service if appropriate.

20. Continue to target and monitor potential risks. Director of follow-up: _____

_____

21. Give special consideration to roommate and close friends who might feel guilty. Specific plan: _____

_____

_____

22. Give special attention to those who may have seen the body. Specific Plan: _____

_____

_____

23. "Prepare to deal with family of victim and roommates family. Other than maintaining consistent institutional sensitivity to the family grief, providing information is the biggest task. A list of university and related officials (including the attorney, insurance agent, and company) with titles and telephone numbers is important. Funeral home address, telephone number and director's name, lists of police officers involved, and the examining medical officer, or doctors also is helpful. It is also a good idea to have one specific university person the family can call at anytime of the day or night. This person can also serve as an escort for the family; picking them up at the airport, taking them to the funeral home, and making other local arrangements. Assistance with necessary paper work, such as securing the police report, and the Medical Examiners report (or autopsy) for the family -- things which may require waiting in unpleasant places -- is appreciated by the family. In addition, compiling the student's university account, loans, prorated bills, refunds and resource person should also be identified. Names of people who have been helpful (planning the chapel or memorial services, backing boxes) should be kept as they may be wanted by the family later. The chronology of all events should be carefully documented." (1977)

Phone Numbers

President _____

Dean _____

Business Manager _____

Attorney _____

Insurance Agent _____

Local Funeral Director _____

24. Be very assertive with coroner's office in determining the cause of death. ASAP. Coroner's Name and Phone Number: _____

_____

_____

25. "Sending flowers, having an institutional representative at the funeral, keeping the family informed of a fund or gift development and coordinating the shipping of any belongings, are responsibilities that remain after the family has returned home. Frequent contact by various staff members for two or three months may be necessary and helpful." (1977)

Specific Plann: Who will send flowers? _____

_____

_____

Who will be responsible for expressions of sympathy? _____

_____

_____

26. Provide specific groups, forums to discuss suicide -- groups like teammates, fellow choir member etc., -- challenge faculty not to ignore -- give them literature. Some concerns may need to be discussed.

Specific plan: _____

_____

_____

27. Continue normal routine ASAP.

28. Be cautious about encouraging attendance at funeral. Some may feel obligated to go out of guilt when it may not be appropriate.

29. Plan for use of the suicide's room and how to manage the floor. Build new associations. Specific plan or strategy: _____

_____

_____

30. "The institution may well wish to assume some costs, such as housing and those for a memorial service, and hospitality for the family, campus transportation, and meals. It may be difficult to face, at an early time, but circumstances may necessitate a clear statement to the family regarding what the institution will and will not absorb. In the long run, this may reduce hard feelings, and legal conflict. Liaison travel and other costs by school representatives should be absorbed wherever possible. If the question presents itself, the institutions's commitment to a memorial should not be ambiguous, but carefully considered and specified. An after-the funeral campus service is best tied to a natural time for the parents and family to be on campus (such as dedicating a memorial or gift) to conserve on costs for the institution and family." (1977)

Institutional Policy Plan: _____

Contingency Budget: _____

Institutional Cost Plan: _____

Memorial Amount: _____

Memorial Service Designate: _____

31. Meet regularly with your staff to attend to your own feelings about the event.

32. If at all possible, use the event to build a greater consciousness that suicide is very real, and that something can be done about it.

Exerpts from the above were taken from William R. Donohue's article "Student Death: What Do We Do"? NASPA Journal, Vol, 14, No. 4, Spring 1977.

VIOLENCE EPIDEMIOLOGY BRANCH PRESS BOOK

The Violence Epidemiology Branch Press Book is an 11 page compendium prepared for the Office of Public Affairs for answering questions about the Violence Branch. The book contains information on the history, goals, and objectives of the Branch, current Branch projects and short bibliographies on self-directed violence (suicide) and interpersonal violence. The category of interpersonal violence includes assaultive behavior among family members, "friends," and strangers. A list of resource agencies which deal with both self-directed and interpersonal violence with addresses and telephone numbers is included. A section of brief capsule biographies of personnel in the Branch and key reference publications by and about the Branch conclude the book.

The impetus for this project was the tremendous number of inquiries the Branch received over the past year about its projects, mission and personnel. In the context of markedly increased attention to the public health dimensions of violence in American society, we felt that such a compendium would facilitate the dissemination of information about the Branch and make for more efficient use of personnel time. We hope the book would assist in both answering requests for information about particular types of violence as well as responding to inquiries about the Branch itself and its specific projects. After consulting with the Office of Public Affairs regarding their needs, we decided on the present format. This Press Book represents the first effort of its kind, and the Violence Branch is the first activity at CDC to compile such a resource for use by the Office of Public Affairs.

Outline

VEB Press Book

I. Introduction

II. Branch Projects

III. Major Facts

A. Interpersonal violence: Homicide and assaultive behavior

B. Suicide and self-destructive behavior

IV. Bibliographies

A. Interpersonal violence: Homicide and assaultive behavior

B. Suicide and self-destructive behavior

V. Resources

A. Interpersonal violence: Homicide and assaultive behavior

B. Suicide and self-destructive behavior

VI. Capsule Biographies

Violence Epidemiology Branch Press Book

I. Introduction

The Violence Epidemiology Branch, Center for Health Promotion and Education, was established by the Centers for Disease Control in 1982 to carry out epidemiologic research in the area of violence. Its primary charge is to reduce the incidence of violence-related morbidity and mortality in the U.S. This is consonant with the Surgeon General's 1990 Objectives on stress and violence which place high priority on the reduction of homicide among black youth, adolescent suicide, and child abuse.

Objectives of the Branch include the quantification and description of morbidity and mortality associated with personal violence, the determination of populations with highest risk for personal violence, and the definition and evaluation of potential risk reduction and prevention measures. The Branch is also concerned with measuring the incidence and prevalence of violence and violent behavior and epidemiologic research.

The Violence Branch is a multidisciplinary team composed of two psychiatrists, Mark Rosenberg and Lucy Davidson; three statisticians, Jack Smith, Bill Rokaw, and Judith Conn; a sociologist, Jim Mercy; a criminologist, Linda Saltzman; a medical anthropologist, Michael Gorman; and two secretaries, Donna Hiett and Amy Bass.

II. Branch Projects

The Branch is currently involved in a number of projects. Among these are:

(1) A study of over 5,000 homicides in Los Angeles County in collaboration with researchers at the University of California at Los Angeles. This study examines patterns of homicide victimization in Anglo, Black, and Hispanic racial/ethnic groups and the association of risk factors such as alcohol use with homicide victimization.

(2) Studies of adolescent suicide clusters. The objectives of these studies are to characterize those adolescents at highest risk of suicide; to explore the effects of imitation, modeling, and social networks on adolescent suicide; and to examine the relationship between violence and mental illness in families and subsequent teenage suicide. These studies are being undertaken in collaboration with the Texas Department of Health.

(3) A study of domestic assault in Atlanta. The Branch in cooperation with the Atlanta Department of Public Safety, the Georgia Department of Human Resources, and the Fulton County Health Department is reviewing social service, medical, and criminal justice case records of homicides and non-fatal assaults between family members and intimates. This study will fill a void in the existing knowledge-base regarding precursors of violent assault, and may suggest specific directions for further epidemiologic studies of homicides and assaults.

(4) A Homicide Surveillance report, published in 1983. This report, the first of its kind, presents and analyzes information on national trends in homicide for the years 1970-1979.

(5) The Suicide Surveillance Report and the Youth Suicide Surveillance Report, to be published in early 1985, present and analyze information on national trends in suicides for the years 1970-1980. These reports are based on published and unpublished data derived from the National Center for Health Statistics death certificate information.

(6) Carter Center "Closing the Gap" Health Policy Project. This position paper describes the health and societal cost of homicide, suicide, and domestic violence and estimates the extent to which these costs could be reduced or eliminated by various preventive interventions.

(7) Other projects include: a study of marital status and suicide; monitoring the 1990 objectives related to homicide and suicide; the development of a domestic violence injury reporting system; a minority homicide surveillance report; and the development of uniform criteria for the classification of suicide. Currently, the Violence Epidemiology Branch is collaborating with the National Institute of Mental Health and providing technical assistance to the Martin Luther King Center for Non-Violent Social Change.

III. Pertinent Facts

A. Interpersonal violence: homicide and assaultive behavior

Homicide claims approximately 23,000 lives in this country every year (Homicide Surveillance Report). Young black males have the highest victimization rate. For the average American the chance that he or she might become a homicide victim in his or her lifetime is about 1 in 150; for a white American woman 1 in 450; for a black male 1 in 28 (FBI Uniform Crime Reports, 1982); for a young, black man 20-24 years of age if he should die, the odds that his death will be due to homicide are greater than 1 out of 3 (MMWR, September 9, 1983).

- From 1970-1978, 178,467 homicide deaths were reported to the National Center for Health Statistics by the fifty states and the District of Columbia.

- Firearms and explosives were the weapons most commonly used in homicide.

- Victims of homicides were disproportionately represented by young people, males, and racial minorities.

- Compared with other causes of death in the U.S., homicide ranked fourth.

Unlike other forms of aggravated assault, spouse battering may involve ongoing and escalating violence accompanied by sexual assault or frequent threats. Data on the number of women beaten in such settings each year are poor. Estimates range from 1.8 to 4 million women each year. While the injuries suffered by abused women do not typically result in hospitalization, they often do. More important than the cost of hospitalization, however, is the enormous strain on medical resources represented by battering. Nineteen percent of all emergency room visits by women with injuries involve battering. Victims of wife battering are at greatly elevated risk of alcoholism, drug abuse, attempted suicide, child abuse, rape, and mental health problems, including severe depression and psychosis (Carter Project Report).

B. Suicide

Suicide ranks as the fifth highest cause of death in terms of potential years of life lost. Approximately 27,000 lives are lost to suicide each year (Suicide Surveillance Report). The most disturbing trend in suicide statistics for this country is the more than tripling of suicide rates for young persons 15-24 since 1950. Most of this increase is due to an increase among young white men. Persons at high risk for suicide include those with serious depression, those with manic depressive or schizophrenic illness, and those with a high degree of social isolation. However, the roles of drugs and alcohol, socioeconomic class, education, sexual identity problems, and family patterns such as divorce and frequent geographic moves remain to be established.

- From 1970-1980, a total of 287,322 suicide deaths occurred in the U.S.

- For the period 1970-1980, whites had suicide rates almost twice as high as blacks and other races, and males had suicides rates almost three times as high as the rates for females.

- o The region with the highest suicide rates is the West.
- o Suicide deaths are most likely to occur in March, April, or May.
- o In 1980, 57.3% of all suicides were caused by firearms.
- o Unlike suicides, suicide attempts occur most frequently among women. Little is known about the epidemiology of suicide attempts.
- o The Violence Epidemiology Branch is very interested in reports of suicide clusters or potential clusters.

IV. Bibliographies

A. Interpersonal violence: homicide and assaultive behavior

1. Homicide

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b. Jerath BK, Larson PE, Lewis JF. Homicide: A Bibliography of Over 4,500 Items. Augusta, GA.:Pine Tree Publications, Inc., 1982.

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2. Domestice Violence

a. Finkelhor D. Gelles RJ, Hotaling GT, Straus M A. The Dark Side of Families: Current Family Violence Research. Beverly Hills:Sage Publications, 1983.

b. Straus MA, Gelles RA, Steinmetz SK. Behind Closed Doors: Violence in the American Family. New York:Anchor Press/Doubleday, 1981.

c. Walker LE. The Battered Woman. Harper and Row, 1979.

d. Walker LE. The Battered Woman Syndrome. Springer Publishing Co. 1984.

e. Wife Abuse in the Medical Setting: An Introduction for Health Personnel. Published by National Clearinghouse on Domestic Violence, April 1981. Domestic Violence Monograph Series, Number 7.

B. Suicide and self-destructive behavior

1. Perspectives on suicide in adolescence. Paul C. Holinger and Daniel Offer in Research in Comments and Mental Health, 1981;2:139-57.

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3. Petzel SV, Riddle M. Adolescent suicide: epidemiological and biological aspects. Adolesc Psychiatry 1978;6:239-66.

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5. Crashaw R, Bruce JA, Eraher PL, Greenbaum M, Luderman J. An epidemic of suicide among physicians on probation. JAMA 243(19):1918-1917.

6. Ashton JR, Donnar S. Suicide by burning or an epidemic phenomen: an analysis of 82 deaths and inquests in England and Wales in 1978-9. Psychol Med 1981;11:735-9.

V. RESOURCES

A. Interpersonal violence

1. Homicide and assaultive behavior

a. Bureau of Justice Statistics reports. 800-732-3277 (local 251-5500). National Criminal Justice Reference Service, Box 6000, Rockville, MD 20850.

b. Criminal Justice Archive and Information Network, P.O. Box 1248, Ann Arbor, MI 48106 (313-764-5199).

2. Domestic Violence

Local

a. Council on Battered Women
P.O. Box 54737
Atlanta, GA 30308
Louise Bill
Program Director

24 hour hotline; emergency shelter 30 days
(404) 873-1766

b. Georgia Council on Child Abuse
250 Georgia Ave., S.E., Suite 203
Atlanta, GA 30312
Includes Parents Anonymous
Incest Helpline, (404) 688-0699
(404) 688-0581

c. Grady Rape Crisis Center
Peg Ziegler, Director
(404) 588-RAPE (588-7273)

d. Men Stopping Violence (A self-help group for men who batter)
Gus Kaufman - (404) 325-0017
Dick Bathrick - (404) 636-5875

National

e. National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD
Ellen Mowbray is Victim Specialist
(202) 251-5500

f. National Institute of Justice (NIJ)
FTS number 724-2949
633 Indiana Ave., NW
Washington, D.C. 20531

g. National Center for Child Abuse and Neglect (NCCAN)
U.S. Children's Bureau
P.O. Box 2282, Washington, D.C. 20013
Aeolian Jackson, Head of Research
FTS number 245-2840

h. National Coalition Against Domestic Violence
1500 Massachusetts Avenue, N.W.
Suite 35
Washington, D.C. 20005

i. National Institute for Dispute Resolution
1901 L Street, N.W.
Suite 600
Washington, D.C. 20036
Michael K. Lewis, Deputy Director
(202) 466-4764

j. C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
205 Oneida Street
Denver, CO 80220
(303) 321-3963

Other

k. New Hampshire Family Violence Research Program
Family Research Laboratory
University of New Hampshire
Durham, NH 03824
Murry Straus
David Finkelhor
(603) 862-2761

l. Police Foundation
1001 22nd Street, N.W.
Suite 200
Washington, D.C. 20037
(202) 833-1460

B. Suicide and self-destructive behavior

1. American Association of Suicidology
2459 S. Ash
Denver, CO 80222
303-692-0985

2. National Center for Health Statistics
3800 East West Hwy, Rm 157
Hyattsville, MD 20782
301-436-8980

3. Suicide Information and Education Center
Suite 201, 723 14th Street N.W.
Calgary, Alberta, Canada T2N 2A4
403-283-3031

VI. Capsule Biographies

AMELIA E. BASS, is a secretary and typist for the Violence Epidemiology Branch.

JUDITH M. CONN, statistician within the Violence Epidemiology Branch, received her Masters of Science degree in Statistics from Emory University in 1975. As the statistician within the the Branch, she has been involved in many of the Branch activities, most specifically, suicide-related studies and the "Closing the Gap" Carter Project.

LUCY DAVIDSON, M.D., is an EIS Officer assigned to the Violence Epidemiology Branch. She received a B.A. in English from Emory in 1970 followed by M.Ed. (1971) and Ed.S. (1974) degrees from Georgia State University. She graduated from Emory University School of Medicine in 1981 and trained in psychiatry at the Emory University Affiliated Hospitals. Her research interests include adolescent suicide, cluster suicides, and contagion theory and suicides.

MICHAEL GORMAN, Ph.D., M.P.H., is a medical anthropologist with training in epidemiology. He completed his doctorate at the University of Chicago and his epidemiologic training at the School of Public Health, University of California at Berkely. His special research interests include adolescent suicide, suicide contagion, adolescent subculture, and the application of epidemiologic methodologies to the study of violence. He is a second-year EIS Officer.

DONNA C. HIETT, has been with the Violence Epidemiology Branch since its inception and is currently the chief secretary for the Branch. She handles scheduling for the Branch Chief and Assistant Chief and can answer or appropriately refer information calls requiring more specific information.

JAMES A. MERCY, Ph.D., is Assistant Branch Chief of the Violence Epidemiology Branch. Dr. Mercy received his Ph.D. from Emory University

in 1982, having specialized in the areas of criminology and research methods. Dr. Mercy received his undergraduate training at Washington and Lee University in Virginia. He is primarily responsible for research in the area of interpersonal violence, with a special emphasis on homicide.

WILLIAM ROKAW, is a statistician with training and experience in epidemiology and computer systems. He received his B.S. and M.P.H. from UCLA. Prior to joinging the Violence Epidemiology Branch, he worked with the Los Angeles County Health Department.

MARK L. ROSENBERG, M.D., M.P.P., Chief of the Violence Epidemiology Branch, is a physician with training in internal medicine, psychiatry, and public policy. He worked previously at CDC as an epidemiologist in the Enteric Diseases Branch and is interested in applying a multidisciplinary approach as well as traditional epidemiologic methods to the study of violence as a public health problem.

LINDA E. SALTZMAN, Ph.D., received her A.B. in Psychology from Brown University in 1971 and earned an M.S.(1973) and Ph.D.(1977) in Criminology from Florida State University. She is currently an Associate Professor in the Mankato State University Sociology Department in Mankato, Minnesota, on a two-year leave of absence. At the Violence Epidemiology Branch she is a "Visiting Scientist" working primarily in the area of family violence.

JACK C. SMITH, M.S., a career statistician with the Centers for Disease Control for 18 years, serves as the Senior Statistical Consultant for the Branch. Mr. Smith has authored or co-authored over 50 articles in major health, medical, and demographic journals and holds faculty appointments at several leading universities. His work in suicide and homicide has focused primarily on the descriptive epidemiology of risk factors by race, by Hispanic ethnicity, by marital status, and by temporal patterns. He is currently coordinating a working group exploring uniform criteria for the classification of suicide.

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